October 4, 2010

Mr. Jay Angoff
Director
Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
200 Independence Avenue Southwest
Washington, D.C. 20201

Re: Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act, 45 CFR Part 170

Dear Mr. Angoff:

Thank you for the opportunity to provide feedback on your request for comments on the Exchange-related provisions of Title I of the Patient Protection and Affordable Care Act (PPACA). Minnesota, like many other States, will not be able to provide detailed answers to many of the questions posed in this request for comments as State officials are in the early stages of gathering diverse perspectives on broad Exchange-related questions. We anticipate that Exchange-related issues will be discussed in our upcoming Legislative Session and that many creative ideas and questions will arise over the next few months and years. Given the complexity of the topic, we ask that the Department of Health and Human Services (DHHS) engage States in an iterative process regarding the implementation of Exchanges across the country.

We have appreciated the willingness of DHHS officials to meet with State officials on an ongoing basis to discuss Exchange-related issues and we ask that this continue over the next few years. Specifically, we ask that DHHS refrain from providing strict guidelines, but instead provide a variety of acceptable Exchange parameters and establish a mechanism for States to engage DHHS on creative Exchange ideas to facilitate a more competitive market that encourages greater value from health insurers and health care providers.

With this in mind, we strongly urge DHHS to allow for the maximum level of flexibility as allowed under the law. The PPACA acknowledges the diversity of health care markets across the country by permitting a variety of Exchange structures. Flexibility is particularly important regarding the scope and market role of Exchanges and the standards for plan certification and rating, network adequacy, marketing, and risk adjustment. Flexibility in these areas will allow States like Minnesota that have enacted nation-leading reforms to improve quality and reduce cost through measurement, transparency, care redesign, and payment reform to take full advantage of the possibilities of an Exchange to facilitate a more competitive market, while avoiding adverse selection between an Exchange and the outside market.

There are areas where clear and early guidance would help States evaluate the range of Exchange options and costs. For example, guidance on the essential benefit set will help States evaluate the impact on State coverage laws and State-based coverage programs such as MinnesotaCare. Guidance on interoperability standards and whether the federal government will establish a basic information technology infrastructure template for Medicaid and subsidy eligibility determination will help States assess the level of resources that would be needed to establish and operate an Exchange.

In addition to these general comments, we have also enclosed responses to some of the specific questions posed by your request for comments. Our responses are informed by a request for public comment issued by the Minnesota Departments of Health, Human Services, and Commerce in August of this year. Again, thank you for this opportunity to provide comments on the Exchange-related provisions of the PPACA.

Sincerely,

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C. Exchange Operations

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is flexibility likely to be particularly important?

For most aspects of Exchange operations and standards, we strongly urge DHHS to allow for the maximum level of flexibility as allowed under the law. We ask that DHHS provide a variety of permissible Exchange parameters instead of strict guidelines. We also ask that DHHS establish a process for States to engage DHHS and receive timely responses on questions, issues, and innovative ideas.

Health care provider and insurer markets vary throughout the country. Thus, flexibility is particularly important regarding the scope and market role of Exchanges and the standards for plan certification and rating, network adequacy, marketing, and risk adjustment. Flexibility in these areas will allow States like Minnesota that have enacted nation-leading reforms to improve quality and reduce cost through measurement, transparency, care redesign, and payment reform to take full advantage of the possibilities of an Exchange to facilitate a more competitive market, while avoiding adverse selection. We also ask that federal Exchange regulations pertaining to governance structure give States the flexibility to pursue options to address State Exchange goals within their specific State laws without the complication of additional federal rules.

There are some areas where clear and early uniform guidance would help States evaluate the range of Exchange options and costs. Clear and early guidance on the parameters for the essential benefit set will help States evaluate the impact on State coverage laws and State-based coverage programs such as MinnesotaCare. Early guidance on the availability of federal data and uniform eligibility requirements for Medicaid and subsidies will help simplify the eligibility process for consumers and reduce administrative costs for States. Guidance on interoperability standards and whether the federal government will establish an information technology infrastructure for States to use as a template will help States assess the level of resources needed to establish and operate an Exchange.

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs?

Review of premium increases must take into account both affordability and solvency. Depending on what States determine to be the role of an Exchange, rate review and plan certification may be functions best performed by State insurance regulators instead of Exchanges. Rate review and most certification requirements are inherently insurance regulatory functions. Thus, to avoid duplication of regulation, reduce administrative/operating costs, and utilize existing experience and expertise effectively, federal regulations should acknowledge that Exchange rate review and certification functions may be conducted by or in consultation with State insurance regulators.

D. Qualified Health Plans (QHPs)

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

One of the most important considerations regarding the certification of qualified health plans for an Exchange relates to adverse selection between an Exchange and the outside market. Although product standards, risk pooling, and risk adjustment provisions in the PPACA will help to mitigate the impact of adverse selection, the existence of different certification/regulatory rules and different types of products inside and outside an Exchange could lead to different types of consumers purchasing inside versus outside an Exchange.

For example, if the rules and types of products inside versus outside an Exchange are different and lead to more extensive and expensive coverage inside an Exchange versus outside an Exchange, the Exchange may only attract individuals and small groups that qualify for subsidies. Those not qualifying for subsidies may be more likely to purchase cheaper insurance outside the Exchange. This is a particular concern for small group enrollment, as the subsidies last for two years. In this example, the more extensive coverage inside the Exchange could also lead to sicker individuals and groups enrolling in the Exchange versus the outside market.

Related to the issue of adverse selection and certification, we ask that DHHS allow and clarify multiple interpretations of risk pooling. One key concern with adverse selection, even if risk is pooled inside and outside an Exchange, is that insurers can establish initial and renewal pricing for products (not for individuals as prohibited by the law) based on the assumed risk selection and actual risk experience of a product. This is a concern if different products are offered inside and outside an Exchange as the products could segment risk and lead to sicker people with higher premiums enrolled in certain products over time in the Exchange versus the outside market. This concern could be addressed in multiple ways. First, States could require all products offered in the Exchange to also be offered outside the Exchange. Second, States could prohibit insurers from using assumed risk selection and actual risk experience in the pricing of products. So, essentially insurers would be required to base pricing on the trend of the whole market adjusted for product characteristics (trends associated with certain benefits and network providers) and modified community rating and wellness discounts for individual enrollees. However, it is unclear whether insurers can adequately separate the trends in the characteristics of products from those of the group of members enrolled or whether regulators can adequately ensure that insurers are not incorporating risk selection/experience into product pricing.

Another point of clarification that is needed is how the risk pooling provisions apply to Exchanges that serve as a group purchaser. If States choose to negotiate with plans in the Exchange to get additional discounts or services, they will need clarification whether the single risk pool applies and whether those discounts/services would be extended to plans sold outside the Exchange. If the single risk pool and same premium rules apply then the discussion above applies, but it is unclear how the Exchange can achieve significant savings compared to the outside market. However, if these rules do not apply, using the Exchange to negotiate additional

discounts or services could discourage participation by insurers. It could also prompt insurers to attempt to attract the best risk outside of the Exchange (since membership in an Exchange is not as constant as with employer group purchasing) and the market could experience adverse selection, particularly for small groups.

Based on the above discussion, we ask that DHHS allow for the maximum level of flexibility allowed under the law regarding certification and the interpretation of risk pooling. This will give States the flexibility to explore which Exchange role (Facilitator, Selector, Purchaser) and scope best fits their market, achieves State goals of improved market value, and best addresses issues of adverse selection.

2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?

As discussed above, certification criteria will be one of the major areas where States need the flexibility to develop innovative solutions that meet the needs of their markets. We ask that DHHS give States the flexibility to determine the certification requirements that are appropriate for their markets, particularly in the areas of marketing and network adequacy where differences in requirements that apply inside and outside an Exchange could lead to adverse selection.

a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

Network adequacy requirements are an important protection to ensure that consumers have access to critical care when they need it. A health plan should not be allowed to limit the availability of services in an attempt to manipulate risk selection. However, rules that are too tight could restrict the ability of health plans to limit provider networks to the most efficient providers. In 2008, Minnesota enacted nation-leading reforms to improve quality and reduce cost through measurement, transparency, care redesign, and payment reform. These reforms provide market incentives for providers to improve the value of care they provide and for health plans to include and incent consumer use of the most valuable providers in their network. Network adequacy requirements that require health plans to be overly inclusive of providers in their network will set back the efforts of States like Minnesota to improve quality and reduce cost in the health care delivery system. We ask that DHHS give States the maximum level of flexibility to determine the appropriate network adequacy and transparency requirements for their markets.

b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

To address the potential for adverse selection inside and outside an Exchange, we ask that federal marketing requirements for the Exchange defer to State marketing rules. To avoid duplication of regulation, reduce administrative/operating costs, and utilize existing experience and expertise effectively, State insurance regulators should continue to bear the primary responsibility for setting and enforcing marketing standards.

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

Please see our response to #1 in this section. We ask that States be given the flexibility to explore which Exchange role (Facilitator, Selector, Purchaser) and scope best fits their market, achieves State goals of improved market value, and best addresses issues of adverse selection. States will need to balance their goals for an Exchange around value, affordability, ease of consumer use, choice, competition, innovation, transparency, and delivery system reform against the potential for adverse selection when deciding what health insurers and products should participate in the Exchange versus the outside market.

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

The definition of the essential benefit set will affect the affordability of insurance offered to consumers and could potentially have an impact on State budgets. Therefore, we ask that DHHS work early with States in the development process of the essential benefit set. Clarity regarding how the actuarial value levels of products will be reviewed and approved is also needed.

We also ask that DHHS clarify the mechanism through which the cost of additional benefits above the essential benefit set will be evaluated to determine State fiscal responsibilities. There may be instances where State additions to the essential benefit set or changes to the delivery of essential benefits could reduce rather than increase costs for insurance and subsidies. With this in mind, we ask that DHHS remain open to creative ideas by States to use potential subsidy savings for things such as additional consumer assistance or market incentives for value-based purchasing.

9. To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act?

In order for States to assess the advantages and disadvantages of the Basic Health Plan option, early guidance on the parameters for the essential benefit set is needed. This is particularly important for States like Minnesota that operate a State-based coverage program like MinnesotaCare. Given that federal funding for a Basic Health Plan will be based on the value of the essential benefit set for the second-lowest cost Silver Plan in the Exchange, early guidance on the essential benefit set is needed. Early guidance will allow States to compare the coverage and fiscal impacts of subsidies for private Exchange coverage, the Basic Health Plan option, and existing State-based coverage programs for individuals between 133% and 200% of the federal poverty level.

E. Quality

1. What factors are most important for consideration in establishing standards for a plan rating system?

States vary in regard to the type of information available on quality, cost, and enrollee satisfaction for health insurers and health care providers. Thus, DHHS should establish a minimum standard based on existing information from local accreditation organizations and allow States to expand from this base. In 2008, Minnesota enacted nation-leading reforms to improve quality and reduce cost through measurement, transparency, care redesign, and payment reform. These reforms provide market incentives for providers to improve the value of care they provide and for health plans to include and incent consumer use of the most valuable providers in their network. Key components of this reform include new and enhanced measurement activities and transparency of cost and quality information for health care providers. We ask that DHHS give States the maximum level of flexibility to determine cost, quality, and enrollee satisfaction metrics for the Exchange. We specifically ask that DHHS refrain from establishing a rating system that would prevent States like Minnesota from incorporating their nation-leading reforms into the Exchange to help consumers make more informed health care decisions.

G. Enrollment and Eligibility

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

PPACA requires Exchanges to provide annual and special open enrollment periods to mitigate adverse selection that would otherwise occur if people were guaranteed enrollment at a modified-community rated price at any time of the year (i.e. people only enrolling in coverage when they are sick, thus creating a sicker risk pool and higher overall premiums). In developing annual and special enrollment periods, States should have the flexibility to structure them in ways that best mitigate adverse selection. This flexibility should include the ability for insurers to underwrite outside of open enrollment periods.

States should also have the flexibility to consider various options for open enrollment periods. For example, some States may want to have open enrollment periods occur at the end of the year for plan years starting in January. Some States may want to have open enrollment periods that more closely match the federal tax return cycle (for example, open enrollment in the spring for a July 1 plan year). This would allow federal income tax information, for which subsidy and Medicaid eligibility will be based, to be more up to date. It would also allow States to build on the awareness of the tax filing deadline to increase awareness and enrollment in health insurance coverage. Other States may opt for a rolling open enrollment period (i.e. related to a person's birthday) to more evenly distribute enrollment and associated resource needs throughout the year. States should have the flexibility to consider these and other options for open and special enrollment periods.

2. What are some of the key considerations associated with conducting online enrollment?

The online eligibility and enrollment system should be as simple to use as possible for consumers and thus, should be streamlined for those who are potentially eligible for Medicaid or subsidies and those not eligible for subsidies. The extent to which the application and enrollment process can be a fully online process will depend in part on how much information applicants will be required to submit that is not in a searchable database accessible by an Exchange or State. If applicants are required to submit paper copies of pay stubs, business records, birth certificates, tax records, letters from doctors proving pregnancy, etc. (as Medicaid applicants are required to do today), this limits the extent to which the process can be a purely online process.

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

Eligibility and enrollment can be most effectively coordinated when policies and processes are aligned and simplified. The PPACA seems to envision a "no wrong door" approach to eligibility and enrollment for both Medicaid/CHIP and the Exchange. Varying requirements for verification of information for the Exchange and Medicaid/CHIP will complicate eligibility determinations and confuse clients.

One of the most significant potential disconnects between the Exchanges and the current Medicaid/CHIP eligibility process is that eligibility for Exchange subsidies and Medicaid could be different. Eligibility for Exchange subsidies will be based on income reported in the previous year tax return, while the PPACA says that for Medicaid, eligibility will still be determined "as of the point in time an application is processed" (Section 2002 (a) amending 42 U.S.C. 1396 a (e) (14) (H)). Addressing this disconnect will be critical to simplifying and coordinating enrollment and easing administrative burden. It will also be one of the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility. The highest level of coordination and lowest level of administrative cost is achieved if the eligibility requirements for the Exchange and Medicaid are the same, except for income level.

Uniform application of other eligibility criteria, such as household size calculation and citizenship/identity documentation, would also promote the "no wrong door" system envisioned in the PPACA. Differences in household size calculation between the Exchange and Medicaid/CHIP could be particularly vexing for both program administrators and individuals.

4. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations?

Minnesota has access to wage information collected by the Department of Employment and Economic Development (DEED). Such information is not available for self-employed individuals. Minnesota also can verify an individual's Social Security number and receipt of

Social Security benefits through the Social Security Administration. Limited information on tax returns is available from the Department of Revenue.

These existing data-sharing partnerships could facilitate eligibility determination for Exchanges. We suggest that implementation of Exchanges also be accompanied by enhanced interstate data systems that facilitate the sharing of basic eligibility information. Federal support and guidance for the development of such systems would be helpful.

H. Outreach

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

Minnesota has considerable experience working with community organizations to assist with State public program enrollment and with business organizations including brokers/agents to assist individuals and employers understand and obtain health insurance coverage. We ask that DHHS refrain from establishing strict guidelines for the responsibilities and requirements of Navigators. The roles and training needs of Navigators may vary depending on how States and Exchanges may want to use them to help various populations with different needs understand and obtain health insurance coverage.

I. Rating Areas

1. To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)? What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? What insurance markets are typically required to utilize these premium rating areas?

Minnesota does not use established premium rating areas. State law allows insurers to establish geographic rating areas, but these areas must include at least seven contiguous counties and be actuarially approved.

K. Employer Participation

4. What other issues are there of interest to employers with respect to their participation in Exchanges?

Minnesota has done studies with small employers in recent years related to health insurance coverage. Small employers in these studies have reported that cost, lack of predictability, and administrative burden associated with obtaining and maintaining health insurance coverage are factors that play into their decision to offer coverage. An Exchange could help employers by establishing a defined contribution approach to coverage. This approach could reduce costs for employers, provide a way for employers to better predict future health insurance costs, and

reduce administrative burden as the choice of coverage would reside with the employee versus the employer. If an employer chooses an Exchange to allow its employees their choice of health plans and products, the ability to write a single check each month to the Exchange will be particularly helpful to employers to simplify the administrative process. Clarification that this is an acceptable Exchange function would be helpful.

States and employers also need clarification regarding defined contribution and whether it is acceptable for premiums to vary according to the modified community rating factors such as age and geography allowed under the law. For example, will it be acceptable for premiums for older employees to be higher than those for younger employees in the same company? According to 29 CFR 1625.10 (d) (4) (ii), it appears that premium differentiation by age is not considered discrimination for groups as long as the proportion of total premium required to be paid by participants does not increase with age. Clarification of this point would be helpful, especially for modified community rating factors other than age.

L. Risk Adjustment, Reinsurance, and Risk Corridors

2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

The type and level of information currently collected within States related to health status, claims history, and medical conditions varies significantly by State. In 2008, Minnesota enacted health reform legislation that enabled the collection of encounter data from all health plans operating in the State, including the Medicaid and Medicare programs. This data is being used to establish an all payer claims database (APCD) for the purpose of creating composite cost and quality measures for health care providers.

Under the PPACA, DHHS is instructed to work in consultation with States to establish criteria and methods for risk adjustment for individual and small group plans inside and outside an Exchange. Given that the availability of data sources varies significantly by State, we ask that DHHS refrain from establishing a "one size fits all" approach to risk adjustment. Some States may only be able to establish a back end approach to risk adjustment that is more similar to a reinsurance mechanism with payments received after claims are incurred. However, other States have data that could potentially allow them to establish a front end approach to risk adjustment with payments disbursed to insurers at enrollment. This type of risk adjustment mechanism could incent insurers to want to enroll and effectively manage the care of high risk individuals, instead of reimbursing insurers for incurred levels of spending that may not encourage effective care management of high risk individuals. States may also determine that front end and back end risk adjustment mechanisms are needed. Based on this discussion, we ask that DHHS allow States to develop a risk adjustment mechanism that best fits their markets instead of establishing a single federal standard.

10. Are there non-Federal instances in which reinsurance and/or risk corridors and/or risk adjustment were used together? What kinds of special considerations are important when implementing multiple risk selection mitigation strategies at once?

The PPACA recognizes the need to have a stable marketplace with the creation of risk selection mitigation strategies. However, there remains the need for clarity around the order in which the reinsurance, risk corridor, and risk adjustment mechanisms occur. Each of these components are crucially interrelated and must be analyzed and implemented with this in mind. With respect to the reinsurance mechanism specifically, we ask that DHHS clarify that all dollars collected within a State for reinsurance be used to maintain a stabilized market in that particular State. Funding from one State should not be used to subsidize another State.

N. Comments Regarding Exchange Operations

1. What other considerations related to the operations of Exchanges should be addressed? If your questions related to the operations of Exchanges have not been asked, or you would like to add additional comments, you may do so here.

Under Section 1201 of the PPACA, DHHS is instructed to create a 10-State Wellness Program Demonstration Project no later than July 1, 2014 to allow insurers to apply wellness discounts permitted for group plans of up to 30-50% to the individual market. For States considering a possible merger of their small group and individual markets, this demonstration project would allow wellness discounts to apply in the same way to small group and individual market members. Thus, we recommend that DHHS allow this demonstration project to coincide with the implementation of Exchanges and that preference for participation in the demonstration project be given to States that intend to merge their small group and individual markets.